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ABSTRACT

Families First is a family preservation program aimed at providing therapeutic and practical help for families in the Netherlands faced with imminent placement of one or more of the children in out-of-home care. In 1994, the demonstration projects took place in four locations in the Netherlands. Participating were 320 children from 234 families who had been referred by child welfare placement agencies. All had received treatment for more than a week. Assessment of demographic information, treatment activities, family functioning, family burden, stressful life events, psychological situation, behavioral problems, and satisfaction took place pretreatment, at treatment completion, and at 4, 7, and 13 months post-treatment. Results of the assessment indicated that Families First succeeded to a considerable extent in reaching the target group. Ninety percent of children accepted for treatment ran the risk of being placed in out-of-home care. Team leaders and family workers adopted the following important characteristics in their work: (1) long, intensive treatment; (2) 24-hour accessibility to the family; and (3) reformulation of the goals and work points in cooperation with the family. Parents and family workers were satisfied with treatment implementation. At one year post-treatment, 76 percent of Family First children lived at home. Of a comparable drop-out group, 26 percent lived at home. However, family problems in this population were still obvious compared to families and children not referred for care. (Contains 23 references.) (KB)

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Evaluation Study of Families First The Netherlands

ED 443 511

An Overview of the Results

J.W. Veerman, R.A.T. de Kemp, L.T. ten Brink

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Evaluation Study of *Families First* The Netherlands

An Overview of the Results

J.W. Veerman, R.A.T. de Kemp and L.T. ten Brink

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CONTENTS

Introduction 5

1 The Dutch *Families First* Study 7

2 Results and Conclusions 11

3 Summary and Discussion 21

Literature 25

Acknowledgments 27

INTRODUCTION

In 1994, the demonstration projects of *Families First* took place in four different locations in the Netherlands (i.e. the cities of Amsterdam and Rotterdam, the province of Gelderland and the northern part of the Netherlands). *Families First* is a form of intensive family preservation services, i.e. therapeutic help combined with practical help for the family. The program is aimed at families in a crisis situation with imminent placement in care of one or more of the children. This new Dutch program is based for a considerable part on the American 'Homebuilders' model and has been further developed by the Department of Behavior Therapy Projects of the Pedological Institute in Amsterdam/Duivendrecht.

Both in the United States and in the Netherlands, the development of family preservation programs such as *Families First* has involved evaluation studies. In reviews of these studies (see for example Blythe, Patterson, Salley and Jayaratne, 1994) two phases can be clearly identified (see also Jacobs, 1995). The first studies from the seventies and the beginning of the eighties were primarily non-experimental and often showed favorable, thus lower, placement percentages. On average, it was shown that approximately two thirds to three quarters of the children (with exceptions exceeding 90%) still lived at home one year after having completed the program. This confirmed the high hopes and also stimulated further development of programs such as these. More recent studies from the second half of the eighties and the beginning of the nineties, however, somewhat dampened the euphoria. These studies, which was more experimental in nature, showed that many children from the control groups stayed at home as well. The conclusion to be drawn was that the evidence regarding the effectiveness of family preservation programs could be considered 'mixed' at best. As Schuerman, Rzepnicky and Little (1994, page 48) said: 'We suggest that it is not realistic to expect dramatic results in this area given the number and magnitude of the problems faced by many child welfare clients and the short-term nature of family preservation services.'

Considering the relatively small number of out-of-home placement cases in the control groups, the question whether the intended target group was reached became more and more an issue This may be considered the central theme of the second phase of research. It is interesting to note that rather similar phases can also be recognized in other research on the results of the programs with a certain ideological background, e.g. the programs for cognitive development of pre-school children from disadvantaged backgrounds (known as 'Head Start' in the United States; see Jacobs, 1988), the evaluation of therapy effects (Omer and Dar, 1992) and research on protective factors (Masten, Best and Garmezy, 1990). This arouses interest for the next phase. It is to be expected (see, for example, Omer and Dar, 1992; Jacobs, 1995) that studies in the third phase will focus more on questions about the differential effects of the program (e.g. the question whether there are families and/or children who benefit relatively more from *Families First*) and about the demarcation in relation to other programs which aim at the same target group.

Subsequently it is to be expected that more attention will be paid to psychological mechanisms which enable us to explain the functioning (or non-functioning) of the treatment. As a result, more attention is paid to process research (De Kemp, 1995). The Dutch evaluation study has been launched in order to contribute to the justification of *Families First* in the Netherlands (Jagers, 1995). According to the 'Van Dale Groot Woordenboek der Nederlandse Taal' (Dictionary of the Dutch language) 'to justify' is 'to prove to be the person one claims to be'. In other words: the study should prove that *Families First* is indeed the program it claims to be: a program which realizes in a certain prescribed way, with an intended target group, what it has claimed to realize. On the basis of this justification question, the study entails the following main questions:

1. Does the program reach the intended target group?
2. Are the intended treatments provided?
3. Are the intended results achieved?

A series of final reports (Veerman, De Kemp and Ten Brink, 1996, 1997; De Kemp, Veerman and Ten Brink, 1996a, 1996b, 1997) have been compiled from the evaluation study. The first final report presents the backgrounds and aim. The three other reports revolve around answering one of the three main research questions. The present report serves as a summary of the final reports. It is, however, written in such a way that it may be read separately as well.

In chapter 1 of this report, the background of the *Families First* project and the evaluation study will be described. The aim, participants, assessment tools and procedures involved in the study are indicated. In chapter 2, the results and conclusions will be presented, after which chapter 3 will conclude with a summary and a discussion.

1 THE DUTCH FAMILIES FIRST STUDY

Background

Organization of the projects

Families First projects are part of a child welfare organization. Referral of families is therefore exclusively executed by the official child welfare 'placement agencies' recognized by law. The four demonstration projects were also affiliated to an institute for child welfare. Table 1 shows an overview of this.

Location	Institute
Amsterdam	Sociaal Agogisch Centrum (Social Community Center)
Rotterdam	De Lindenhof / Humanitas
Gelderland	OC-Michiel
Northern Netherlands	Stichting Jeugd & Gezin Friesland / Stichting Jeugdhulpverlening Drenthe (Child & Family Foundation Friesland / Child Welfare Foundation Drenthe)

Table 1 Locations and institutes

A *Families First* project consists of one or more teams with a number of family workers (social workers or group leaders who both have received a *Families First* training), supervised by a team leader. Due to the intensive nature of the care, the caseload is limited to two families per family worker. The team leader is responsible for the daily routine, supervision of the work, and is also in charge of the intake. A program leader is in charge of a *Families First* project. He/she ensures that the project is in accordance with policy. A *Families First* treatment always starts with a referral by an official placement agency recognized by law. This agency has to assess the need of out-of-home placement of the child. The family members are to be informed of this placement and at least one of the parents must have expressed the wish to let the child stay at home and must be prepared to welcome the family worker. The team leader evaluates the referral, which may result in acceptation, rejection or a need for additional information. In addition to the formal, above-mentioned criteria, the child's safety is an important aspect. For *Families First* to be possible, this aspect should be sufficiently protected and, if necessary, supplemented with certain arrangements of *Families First*.

Design of the study

Taking the questions (describing the target group, program activities and results) into account, a longitudinal design is most appropriate. This means that various

kinds of information need to be gathered for all families referred to the *Families First* program, at different points in time: at the start of the program, at completion (approximately one month after the start) and at three follow-up moments, i.e. three, six and twelve months after the program has been completed (thus, respectively four, seven and thirteen months after the start). During the provision of care, the care activities (the 'provided services') are registered. Figure 1 presents the aim of the study.

Start	Care	Completion	1st follow-up	2nd follow-up	3rd follow-up
0 months		1 month	4 months	7 months	13 months
Assessment 1		Assessment 2	Assessment 3	Assessment 4	Assessment 5

Figure 1 Overview of Assessment tools

Participants

In 1994, 320 children from 234 families were treated for more than one week by a *Families First* family worker. It concerned 183 boys and 137 girls varying from babies to children at a maximum age of eighteen years (mean age 10.9). More than half of the children does not live with a caring father figure. A considerable number of children (40%), are from ethnic minorities, that is to say: at least one of the biological parents was not born in the Netherlands. For over 30% of the children judicial actions apply, generally by placement under supervision. The reason for the majority of the referrals (78%) is a lack of parenting. According to the persons referring (half of whom are from the judicial circuit), the parents in these cases are not able to provide the child with adequate parenting and care. The reason for referral is often in conjunction with other reasons, for instance serious behavioral problems of the child.

Assessment tools and procedures

Two basic concepts can be deduced from the research questions about which information was required: factual child placement (based on the actual living situation; and imminence of child placement: based on family characteristics and the child's behavior), for the answer to question 1 (target group) and question 3 (results); and treatment activities (nature and duration), for the answer to question 2 (provided services). In addition to information concerning these basic concepts, it was found important to register further demographic information on the referred child and his/her family, and also to ask for the opinion of the parents and family workers about the treatment (satisfaction). The choice of the research instruments had to be in accordance with these basic concepts. In the first place, Dutch tests or questionnaires were selected with psychometrically acceptable characteristics (sufficiently reliable and valid) and with which also experience in clinical practice was acquired. In the second place, data were required of 'normal' groups (i.e. not referred to child care) and of 'clinical' groups (i.e. referred to child care).

As a consequence, this would enhance the positioning of the *Families First* group in relation to children and families, whether or not referred to a type of child care. Figure 2 shows an overview of the selected tools.

Concept	Tool	Informer	Taken at moment
Demographic information	Scoring scheme File Information (SFI)	Family Worker / team leader	1 to 5
Treatment activities	Time and Activities Form (TAF)	Family Worker	1 to 5
Family functioning	Questionnaire of Family Functioning (QFF)	Family Worker	1, 2, 5
Family burden	Nijmegen Child Rearing Situation Questionnaire (NCSQ, part A)	Parent	1, 5
Stressful life events	Questionnaire of Life Events (QLE)	Parent	1, 5
Psychological situation	Combination list of Psychosocial Variables (COM)	Person referring	1, 5
Behavioral problems	Child Behavior Checklist (CBCL)	Parent	1, 5
Satisfaction	Assessment Scale for Satisfaction and Effect (ASSE)	Parent Family Worker	3 5

Figure 2 Assessment tools

Explanation:

ASSE: assesses satisfaction with and observed effects of treatment of parents and family workers.
CBCL: assesses behavioral problems with children in the age of 2-3 years or 4-18 years.
COM: assesses psychological circumstances and child problem behavior.
TAF: assesses the nature and duration of the activities.
NCSQ: assesses subjectively experienced family stress on eight sub-scales.
SFI: registers demographic and diagnostic data concerning referred children and families.
QFF: assesses the family as parenting environment, particularly the functioning of the parents.
QLE: assesses potentially stressful events (life events) as from birth.

Manuals or protocols of CBCL, COM, NCSQ, SFI, QLE were available. TAF and QFF have been developed within the framework of *Families First*. The ASSE is an adjustment of questionnaires used in some research, reports of psychometric nature have not yet become available. See Veerman, De Kemp and Ten Brink (1996) for more information and the full references with regard to all instruments.

The figures below 'Taken at moment' refer to the above-mentioned five assessment tools (start, completion, and three follow-up moments).

In the process of gathering information, the family workers and the team leader are central figures. The family worker is the person who is most familiar with the family and may, if necessary, check lacking or obscure data. The team leader checks whether all forms are present and is responsible for timely completion and forwarding. He/she acts as the contact for the researchers. The researchers receive all forwarded information, check whether it is complete and, if necessary, call the team leader to account for lacking data. All data are entered into computer programs. A separate Management Information System (MIS) has been devised for the demographic data and the administration of referral and completed questionnaires. This is also used to monitor the appropriate time for gathering certain data and whether data are gathered in time (as an additional check, a kind of 'double check').

An important aspect in the procedures concerns the feedback given by the researchers. First of all, it concerns administrative feedback. A receipt acknowledgment of every received referral is sent (produced by the MIS). Every week, each location is to receive a list including the referrals up to that particular moment, which also includes data as to which questionnaires have been completed and which have not (serves as a reminder). In addition, feedback with regards to contents is provided at the case level. A 'result' is made of the appropriate questionnaires (a kind of profile) for each family or each child by the researchers, which is sent to the location within a week or fourteen days. This serves to provide additional information to be used with the diagnostics and treatment planning. This is realized for the CBCL, the NCSQ, the SFI, the TAF and the QLE. Team leaders and/or family workers are requested to correct any errors in the feedback and return it. As a result, an opportunity is created for error correction in gathering data or data entry. Finally, there is feedback at group level. During the year of the study, an interim report is drawn up after each quarter, which each time also highlights an aspect of the study with regard to its contents and is substantiated by figures, in addition to a representation of the most recent 'counts' (i.e. number of children and families involved in the project and the response to various questionnaires).

2 RESULTS AND CONCLUSIONS

The discussion of the results and conclusions is based on the three main questions of the study. Due to the summarizing nature of this publication, only outlines of the results are discussed. If you wish more detailed information, please refer to the research reports concerned.

Question 1 Does the program reach the intended target group?

The target group of *Families First* concerns families faced with imminent risk of out-of-home placement of the child. This in itself seems to be a clear criterion. However, the discussion about the way in which this criterion is operationalized as effectively as possible serves as a leitmotiv for the research literature. Not only the definition of the risk of child placement may vary considerably (from a single-parent family to court ruling), risk assessment is also bristling with pitfalls. Insufficient information during the decision-making process, alterations in the family situation during the decision-making process, the standards and values of the family worker, the fact whether the family co-operates or not, considerations of political nature in accordance with policy and insufficient capacity in residential institutes render the decision-making process obscure and unreliable from a scientific perspective (different family workers will arrive at different conclusions, the same family worker may take a different decision at a later point in time). In addition to this, it may also be the case that for families which are referred to a new program such as *Families First*, the risk of child placement is rather limited (see Veerman, De Kemp and Ten Brink, 1996, for a more detailed consideration). Partly as a result of this type of experience, Rossi (1991) recommends not just to take the impending threat of child placement in account, however, also the factors that cause the decision for child placement. Knorth (1995) shows that factors of the family environment (including parenting incompetence, neglect, insufficient capacity) and factors with regard to the children (mainly externalizing, aggressive behavior) play a part in this. In this study, on the basis of the above-mentioned considerations, we opted for a two-track policy with regard to the question whether the intended target population has been reached: (1) Problems with children and their families have been assessed and based on these and an answer is sought to the following questions: Does the *Families First* group have more problems than families without care needs? Does the *Families First* group have just as many problems as the residentially treated children? The following four problem areas have been studied: behavioral problems, family stress, experienced stressful life events and the psychosocial situation. (2) On the basis of the assessed problems the risk of child placement is assessed.

Problems of children and their families

The children in the *Families First* group seem to be characterized by serious behavioral problems. The average result for a number of dimensions of the problem behavior equals or even exceeds the results of residential groups. Delinquent and aggressive behavior are especially striking.
At all scales of a questionnaire measuring the degree of subjective family stress, the results of the parents in the *Families First* group are higher than the parents in 'normal' groups. They have much difficulty in accepting their child, are no longer able to cope with the situation and experience their child as a heavy burden. In addition, just as parents of children placed in care, they feel strongly that they have to cope with parenting alone and receive just as little pleasure from the relationship with their child. For two years prior to referral to *Families First*, the children have experienced more stressful events than a comparative group of children not enrolled for care, and they have experienced at least just as much of this type of events as children placed in care. Arguments between parents and between parents and the child are common. In addition, the parents refer regularly to events such as divorce and trouble with the police due to vandalism and theft. According to the persons referring, it generally concerns a very unfavorable psychosocial situation, which is characterized by bad relationships within the family. Physical abuse or incest is just as often an indication for help as it is with residentially treated children. The persons referring confirm the opinion of the parents that aggressive behavior of the child is just as serious as that of children placed in care. All in all, the problems of the *Families First* group seem to deviate considerably from what is considered 'normal' and seem to be quite similar to that of residential groups with regard to the four problem areas studied. There are, however, differences between the various locations. Gelderland and Rotterdam show family stress that is similar to the residential group. In the northern part of the Netherlands, the parents generally experience child parenting less of a burden than parents who have their child enrolled for a residential institute. The Amsterdam parents are in between these two extremes. It may be the case that the problems in the northern part of the Netherlands are less serious than in the so-called 'Randstad' (the urban agglomeration of Western Holland). However, it may just as well be the case that parents in the northern part of the Netherlands are less inclined to 'wash their dirty linen in public', and thus they are somewhat reticent about the contents of the questionnaires. The data, however, do not serve as a sound basis for choosing between these various explanations.

The risk of child placement

How many children qualify for child placement based on the above-mentioned problems? The risk of child placement is estimated on the basis of the results of the questionnaires which represent the four problem domains. These problem areas play an important role in the decision-making process in child placement cases. On the

basis of this, an out-of-home-placement index (OHP index) has been created (De Kemp, Veerman & Ten Brink, submitted). With this, the first assumption is that the more the child's problems in a certain domain show similarities with those of children placed in care, the greater the chances of child placement are. The second assumption is that if serious problems (comparable with residential groups) are identified in several problem domains (psychosocial situation, family stress, stressful events, behavioral problems), the chances of child placement are greater. Since it concerns results in four problem domains, the result at the OHP index lies between 0 and 4. A result of 3 or 4 indicates a great risk of child placement, a result of 1 or 2 indicates a moderate risk and a result of 0 (in neither of the four domains the problems are comparable with that of children placed in care) indicates no risk of child placement.

More than half (59%) of the *Families First* group is identified with problems of such severity that child placement (without involvement of *Families First*) is definitely indicated (in other words: great risk).

Nearly one third of the children (31%) runs a moderate risk of being placed in care and 10% does not run that risk. The age of the child plays a role; older children run more risk. Figure 3 presents a graphic outline of these results.

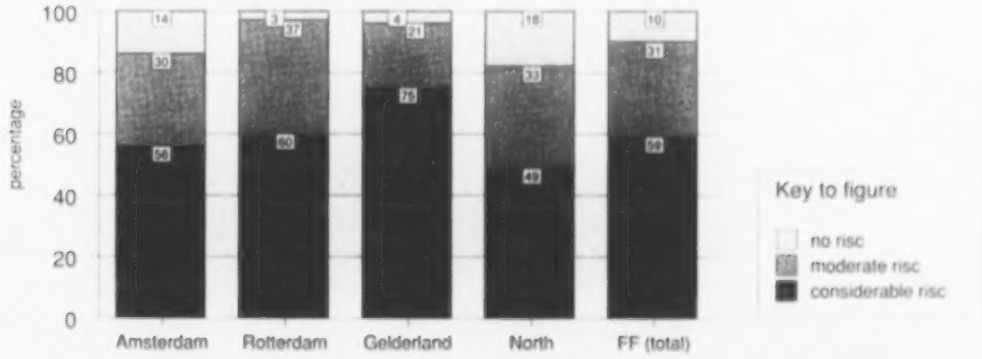

Figure 3 Out-of-home-placement index at the start

Conclusion

The conclusion can be drawn that *Families First* has succeeded to a considerable extent in reaching the target group. Nine out of ten children accepted for treatment with *Families First* due to problems in the family or due to their behavior run the risk of being placed in care. For six out of ten children, problems have accumulated to the extent that the chances of being placed in care can be considered considerable, if *Families First* had not intervened. These children have already experienced quite a number of life events (e.g. divorce of their parents, trouble with the police due to theft or vandalism), the parenting situation is unstable (e.g. as a result of imprisonment of one of the parents or unemployment of the father), the child's relationship with the other members of the family is disturbed, the parent is no longer able to cope with the responsibilities involved in parenting and the child

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shows serious behavioral problems. A more detailed discussion of the results with regard to the first research question can be found in De Kemp, Veerman and Ten Brink (1996a).

Question 2 Are the intended treatments provided?

The answer to this question evolves around two topics: the content of the *Families First* program and the appreciation of parents and family workers for the program. We gain insight into the content of the program by means of the registered treatment activities, henceforth simply referred to as 'activities'. To this end, the family worker completed a Time and Activities Form (TAF) after each contact with the family indicating the nature, date and duration of the activity. With regard to the appreciation, the opinions of parents and family workers about results of and experiences with *Families First* have been listed. As a result, besides gaining an impression about the satisfaction with the care offered, we are also provided with insight into possibly stimulating and interfering factors towards realizing favorable results.

Program characteristics in practice

With regard to the question concerning the content of the *Families First* program, we may distinguish between characteristics of the *Families First* program and the treatment guidelines. These characteristics and guidelines are extracted from the manual for family workers (Berger and Spanjaard, 1996). It appears that, in accordance with this manual, team leaders and family workers adopt the following characteristics of *Families First* in their work:

1. Duration and intensity. On average, treatment involves at least four weeks. The majority of treatments (91%) may vary from what can be considered moderate (22%) to intensive (69%).
2. The 24-hour accessibility. Nearly one third of the total period of care is applied in the evening or during the weekends. The Gelderland location even shows that 43% of care is provided outside office hours. This indicates considerable accessibility and flexibility of the family worker.
3. (Re)formulating the targets and work points. The family workers formulate the treatment targets and work points in co-operation with the family. For approximately three quarters of the treatments, the targets and work points are formulated within three days. For approximately 50% of the treatments the targets and work points are reconsidered after two weeks. With regard to this, striking differences can be identified between the locations. The northern part of the Netherlands, for example, shows that the targets of 71% of the treatments were reconsidered after two weeks, whereas Amsterdam shows a percentage of 31.

Maintaining the program guidelines

As far as the guidelines are concerned, it appears that all locations use the same introduction order with regard to the various treatment activities. This activity order is clearly in line with the guidelines that are presented by the program developers during training. In general, we see that treatment starts with active listening/supporting, around the third day targets are set and around the fourth day acquiring social skills starts. Towards the eighth day the family worker uses confronting 'I-messages' for the first time and, at the same time, practical help is offered. After the 'Confronting I-messages' technique, a start is made with paying attention to techniques for acquiring emotional skills. The technique 'Disturbing and helping thoughts' is generally introduced at the beginning of the third week. Around the 30th day, the *Families First* treatment has finished. With the exception of the moment of practical help, the family workers of each location hardly appear to deviate from the guidelines referred to above. Practical help is not offered until the second week. The family workers show a preference to start with acquiring social skills before practical help is offered. Offering practical help at a later stage is possibly related to some focal points in offering help. In family worker training (and in the corresponding manual) the importance of matching practical help and the wishes of the family are pointed out. In addition, the family worker has to pay due attention to the targets set, the child's safety and the possibilities for building up a professional relationship. It is also possible that the first week as yet fails to provide a clear perspective of the most appropriate form of practical help for the family. Figure 4 is a graphic representation of using the guidelines. It shows what is generally considered as the first day on which a certain group of activities is applied. A separate bar has been allocated to each group of activities. Thus, for example, we first see open space in the bar referring to practical and material help (corresponding to approximately eight days) and then a shaded part. The left and right side of this shaded part indicate the confidence interval of the *Families First* average. In other words, the sides of the shaded part are the margins within which we may state with 95% confidence that this concerns the point at which the *Families First* average for the first day of practical/material help lies. This bar shows that, on average, the *Families First* worker starts with offering practical help between the eighth day and the twelfth day of providing care. We see far less variation in 'actively listening/providing support' on the first day of application. The average day of applying this activity should be sought between about a half and an entire day after care has commenced. So most family workers will start with these basic techniques on the first day. Figure 4 may be considered a profile of *Families First* activities.

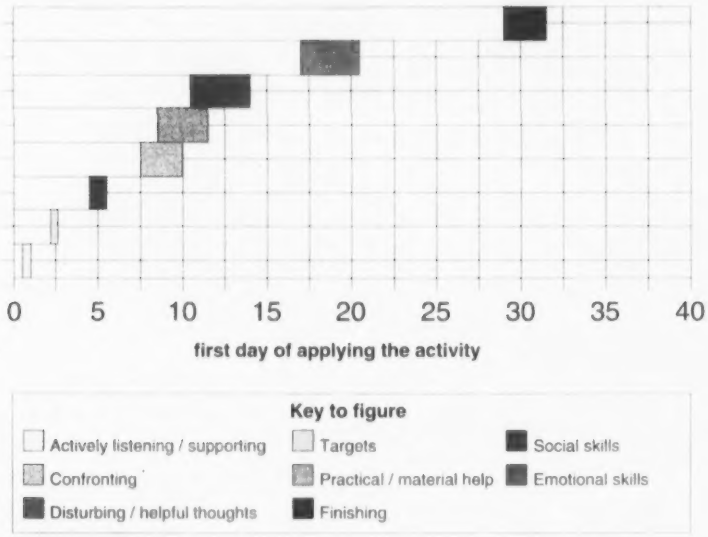

Figure 4 Using the guidelines

Satisfaction with what is offered

Parents and family workers completed a questionnaire concerning satisfaction and effect, respectively after three and twelve months care had been finished. Three months after finishing *Families First*, most parents (70%) experience positive changes in the behavior of their child, family functioning, their way of parenting and their insight into the behavior of their child. The great extent of satisfaction becomes clear from the fact that 92% of the parents would also recommend this form of intensive family preservation to relatives or friends. They consider the behavior-based approach, obtaining structure and support, acquiring a more positive attitude and good contact and co-operation with the family worker to be important ingredients of care. A few parents have expressed their objections to the short period of the treatment and find the follow-up help insufficient.
The assessments of family workers and that of the parent are basically in line with each other. After one year, the family worker sees the child's behavior and the family environment improving in more than 70% of the cases. It is striking to see that the four locations show almost similar percentages. Just as the parents, the family workers point out the necessity of paying more attention to follow-up help. A number of factors emerge from the comment of the family workers that influences the treatment results both positively and negatively. Factors they find to have positive impact on structural improvements within the family and the child's behavior include, among others: an improved family situation (home situation has improved, financial matters are taken better care of, father has joined the family again), improvements with regard to parenting (more care, more structure, more child acceptation), increased self-confidence of the parents and adequate follow-up help. Factors family workers find to have a negative impact include: the complexity of the problems, addiction problems of the parents, denying problems, refusing to

accept responsibility, not being able to put acquired skills into practice, problems in the professional relationship between the family worker and the parent(s) and inadequate follow-up help.

Conclusion

When we finally return to the research question which is pivotal for this paragraph: 'Are the intended treatments provided?' We may answer this question positively. With regard to both relevant characteristics and important guidelines, the treatment in practice is very much in line with the treatment in theory. We can also see a great extent of satisfaction with both the consumers (i.e. the parents) and the producers (i.e. the family workers) with regard to treatment implementation. A more detailed discussion of the results with regard to the second research question can be found in De Kemp, Veerman, and Ten Brink (1996b).

Question 3 Are the intended results achieved?

An important result would be that the child (still) lives at home. *Families First*, after all, aims at preventing child placement. In addition to the fact whether or not the child lives at home, reducing the imminence of risk of child placement would be another important result. This risk has to do with objectively demonstrable and subjectively experienced stress in the family situation and with the problem behavior of the child (please refer to the discussion of the first research question; and to Veerman, De Kemp and Ten Brink, 1996). With this, relieving stress in the family situation and reducing the problem behavior serve as indicators for a possible case of child placement, they serve as a basis for the out-of-home-placement index (OHP index) devised by us. In addition to this, however, they are significant results as such. The results with regard to actual cases of child placement have been established at four moments: when finishing treatment, and three, six and twelve months after treatment had been finished. Changes with regard to the risk of child placement have only been established twelve months after treatment was finished, i.e. at the end of the follow-up period (see also figure 1).

Living at home or not

It appeared that the number of children of the group 'living at home' gradually becomes smaller varying from 92% when finishing the treatment to 76% at the last follow-up (one year after finishing the treatment). Children living at home concern children that live independently or with their parents, family, friends or acquaintances, children living out of home concerns children who have been placed in care of a foster home or residential institution, as well as homeless children. In order to assign a meaning to these figures, they have been set alongside those of treatments that were terminated within one week, referred to as 'non-regular treatments' in the final reports. Of those children 26% still lives at home after one year. Compared to the above-mentioned 76% of the regular treatments, this results

in an indication that if the treatment is finally proceeding well, chances that *Families First* succeeds in preventing child placement of a referred child are considerable. With regard to child placement, the difference between non-regular and regular treatments are statistically significant at all four assessment moments. The fact that hardly any differences with regard to the percentage of children living at home can be seen between the locations is striking. Figure 5 shows a visual representation of the results described above.

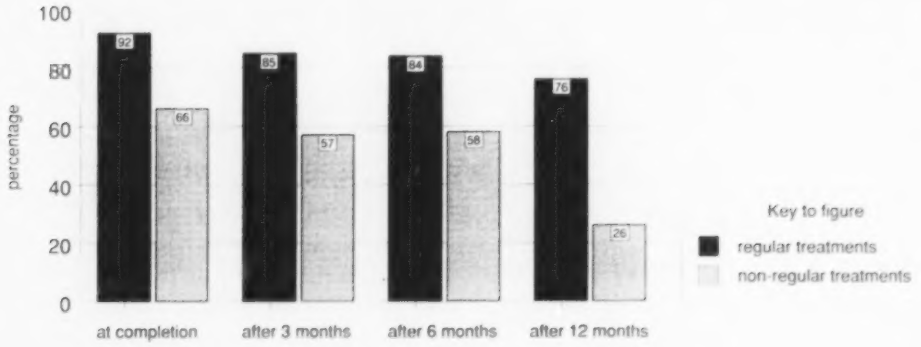

Figure 5 Children living at home with regular and non-regular treatments

Less problems with children and their families

Problems have been reduced to considerably at all four locations one year after finishing *Families First*. Compared to the situation at the start, parents experience the family stress to have become less and observe less behavioral problems with their children. In addition, parents point out that less stressful events have occurred during the follow-up year compared to the year before treatment. Outsiders, i.e. family workers and persons referring, also see meaningful changes. Persons referring see an improvement in the psychosocial situation, they see an improvement of the quality of the relationships of the child with other members of the family and a decrease of the social difficulties experienced by the child, while at the same time, they also see less indications for help due to theft and aggression. Family workers find that parents offer more structure in parenting one year after *Families First* than before, they are also more able to ensure a safe parenting situation than before; in addition, family workers find that the relationship between parents has improved. With these improvements, however, it is striking that parents indicate that the problems within the family are still considered major compared to 'normal' children or families, i.e. those who have not been referred to care.

Less imminent risk of child placement

For 132 children who live at home (independently, with their parents, family, friends or acquaintances) it is possible to determine via the OHP index the risk of child placement at the start and when follow-up takes place (one year after

treatment was finished) based on the above-mentioned indicators. This group shows that more than one third (37%) faces so many problems within the family that the risk of child placement is great. The indicator for child placement is allocated with less certainty to half (50%) of the children, i.e. the 'moderate-risk group'. We estimate that this risk is very low for 13%. At the start of *Families First*, the risks for this group of 132 children was respectively 64, 28 and 8%. Compared to the initial figures, the risk of child placement has decreased with 40% and increased with 11%. With nearly 50% the risk stays the same. These figures confirm the picture that emerges from the analysis of the more specific child and family data: in general the edges are taken off, however, many families are still faced with major problems. Table 2 shows what is described above.

	OHP index at follow-up			
OHP index at the start	no risk	moderate risk	considerable risk	total number
no risk	6	2	2	10
moderate risk	5	2	10	37
considerable risk	7	41	37	85
total number	18	65	49	132

Table 2 Changes of OHP index between start and follow-up

Prediction of child placement

Finally, it is studied whether it can be predicted on the basis of demographic characteristics of either the child or the parents (e.g. gender, age, social-economic status) actual cases of child placement, the risk of child placement and the changes of the risk of child placement, one year after *Families First* had been finished. The examined variables show that one variable can predict child placement at follow-up: the fact whether or not a stepfather is present. Both children who live with their biological father at the start of the treatment and children without a father figure in the family, have a better prognosis as far as preventing child placement is concerned (76% respectively 81% lives at home one year after treatment) compared to children with a non-biological father living with the family (56% lives at home).

Conclusion

The results aimed at are realized to a considerable extent. One year after a *Families First* treatment had been finished, 76% of the children lives at home. Of a comparable drop-out group 26% appears to live at home; a statistically significant difference. If we also take the home situation during the entire year after finishing into account, in addition to the home situation after one year, 70% appears to be living at home all year, therefore during the whole year 30% does not receive any form of residential treatment or foster care. After one year changes in the desired

direction can be established in all four areas of study with regard to the functioning of the child and his/her family. On the other hand, however, one year afterwards, problems are still very obvious compared to 'normal' (i.e. children and families that were not referred to care). The edges may be considered taken off, the problems, however, are not completely solved yet. The latter also appears from the figures on follow-up help, not given in the present report. Only 2% of the children receives absolutely no help in the year after *Families First*, nearly 30% receives exclusively out-patient care, 3% has been placed in care during the entire period, and 65% alternates help (between 'no help' or out-patient care, or between out-patient treatment, day treatment or residential treatment). A detailed discussion of the results with regard to the third research question can be found in De Kemp, Veerman and Ten Brink (1997).

3 SUMMARY AND DISCUSSION

In 1994, the demonstration projects of *Families First* took place in four different locations in the Netherlands. *Families First* is a form of intensive family preservation services, i.e. therapeutic help combined with practical help for the family. The program is aimed at families in a crisis situation with imminent placement in care of one or more of the children. The evaluation study of *Families First* revolves around three main questions:
1. Does the program reach the intended target group?
2. Are the intended treatments provided?
3. Are the intended results achieved?
The group to be studied consists of treatments which started in 1994 at the four locations. It concerns 320 children from 234 families. This chapter summarizes and discusses the results.

With regard to the first research question, the conclusion may be drawn that *Families First* has succeeded to a great extent to reach the target group. Nine out of ten children accepted for enrollment with *Families First* for treatment run the risk of being placed in care due to behavioral problems or problems within the family. For six out of then children the problems have become accumulated to the extent that chances of being placed in care can be considered considerable, if *Families First* had not intervened. These children have already experienced quite a number of life events (e.g. divorce of their parents, trouble with the police due to theft or vandalism), the family situation is unbalanced (e.g. as a result of imprisonment of one of the parents or unemployment of the father), the child's relationship with the other members of the family is disturbed, the parent is no longer able to cope with the responsibilities involved in parenting and the child shows serious behavioral problems.
The second research question can also be answered in the affirmative. With regard to both relevant program characteristics and important guidelines, the treatment in practice is very much in line with the treatment in theory. We can also see great satisfaction with both the consumers (i.e. the parents) and the producers (i.e. the family workers) with regard to the implementation of the treatment.
The third research question may also be answered positively to a considerable extent. One year after *Families First* had been finished, 76% of the children lives at home. Merely 26% of a comparable group, which consists of drop-outs, appears to live at home. During the entire year after finishing, 70% appears to be living at home all year. After one year, changes in the desired direction can be established with regard to the functioning of the child and his/her family. Things are improving. The imminent threat of child placement has also decreased. On the other hand, however, one year afterwards, problems are still very obvious compared to 'normal' families (i.e. children and families that were not enrolled for care). The conclusion may be drawn that the edges are taken off, the problems, however, are not

completely solved yet. The latter also appears from the figures on follow-up help which are not given in the present report.
Reviewing the results, it seems that a large group of children which were about to be placed in care, may continue living at home as a result of intervention of *Families First* and that important improvements in the child and family functioning have been realized. As a result, intervention by *Families First* in case of imminent child placement is certainly worth considering. These results are very much similar to the results obtained from studies in the United States (see Blythe, Patterson Salley and Jayaratne, 1994; Rossi, 1991).
A significant discussion item is that the result cannot be attributed unequivocally to the *Families First* treatment due to the fact that a control group of untreated children and families was lacking. Other factors, for example a solution of the crisis, or help from friends or neighbors, may also cause the results in question. In the fourth final report we indicated that we are of the opinion that these alternative explanations are very unlikely (De Kemp, Veerman and Ten Brink, 1997, page 85-86). An important argument is that we were able to show that *Families First* treatments were executed in practice as intended. This means that the theoretically basic conditions have been met in order to instigate a process of change, 'logically following' from this was that the changes actually took place. Another argument is that merely 26% of the children of an internal comparable group, of whom treatment was terminated prematurely, lived at home after one year (compared to 76% of the *Families First* group), a figure which shows striking similarities with the percentage of 20% of cases, referred to by Knorth and Dubbeldam (1995), which were indicated for residential care still living at home after six months (e.g. because they could not be enrolled, the crisis seemed to be resolved, etc.). This suggests that *Families First* has better results than the 'natural course'. All this does not mean that the option for creating an adequate control group need not be given serious thought in future studies.
Another discussion item concerns the question to what extent it concerned an actual risk of imminence of child placement in the target group. For if this was not the case, it would be relatively easy to prevent child placement. Schuerman, Rzepnicky and Little (1994) also suggested that due to the generally implicit criteria used by persons referring for having a child and family enrolled with a program like *Families First*, exactly those families are enrolled with which the risk of, at least short-term, child placement is low. In other words: chances would be great that preventing child placement without intervention by *Families First* would have succeeded anyhow. Although this possibility cannot be ruled out completely, a few counter arguments may be put forward.
First of all, identification of serious impending child placement was a clear criterion with the referral, which has been given careful consideration in the decision-making process. Secondly, based on the out-of-home-placement index, we were able to clearly identify the fact that with 90% of the enrollments, the child and family problems were of such a nature that child placement could be considered probable or very probable. In addition, this index calculated at the start of the treatment appeared to have little predictive meaning with regard to the fact whether or not

placement in care would have taken place one year after treatment had been finished. This may be considered as the non-validity of the index, it is more likely, however, that the *Families First* treatment was also successful with children and families with serious problems. It is, however, recommended to document the indication for child placement in more detail in future research.

The study also resulted in a number of recommendations with regard to contents. The most significant recommendation is indeed that the program hardly requires any adjustment in its current form. The treatment appears to be executed as it is intended and to realize results aimed at. However, considering the major problems which we are still able to identify with a large number of families and the suggestions of the parents and family members to strive for a better match between the follow-up help and *Families First* (De Kemp, Veerman and Ten Brink, 1996b), more attention needs to be paid to seeking the most suitable follow-up help. Geene (1995) argues in favor of forming a path of care in co-operation with the parents, which the family is to follow already at the stage when a crisis situation in a family is established and they are referred to *Families First*. Within the Dutch multi-functional organizations, he distinguishes paths of care which begin with crisis care. By establishing such paths in advance, the family is provided with a perspective which is as realistic as possible. Thus it is emphasized that *Families First* is not able to solve everything within four weeks, yet *Families First* aims at dealing with the crisis within the family, instigate a process of change and cancel the necessity of child placement. Drawing up paths of care is, in any case, recommended for children who run a great risk of child placement. For some families, a few short contacts with family workers at some points in time to be determined in advance after treatment has been finished will probably suffice.

The treatment as conducted in this study project had three follow-up moments during the year after completion. There are reasons to believe that this has partly contributed to the results to sink in. Kazdin (1987), for example, suggests to use a chronic disease model by analogy to diabetes with a group of children with serious behavioral problems and with a major dysfunctional parenting situation. The problems will never disappear completely, however, they can be dealt with if only regular 'checks' are conducted. For Veerman (1990) this was reason to argue in favor of contacts in an out-patients department after a period of intensive residential treatment. The follow-up measurements conducted within the framework of the current evaluation study probably have the exact same function and effect. In another terminology, we are dealing with a form of social support which probably serves as a protective factor; i.e. a factor which, in spite of the stress present, ensures that child and family are able to function reasonably adequate. Follow-up contacts which form an integral part of the treatment, are elements of a path of treatment as referred to above. With this, the postponement of child placement, which is what is minimally realized by a *Families First* treatment, is continued.

As far as the recommendations for further studies are concerned, it seems particularly important to continuously raise the research questions (with regard to the reached target group, the treatments provided and the results realized) and answer them, for example, in the form of 'annual statistics'. This may not only

contribute to further professionalization of family workers, but also gives account to 'outsiders', for example the government, the financiers and the clients proper, and providing more profile for *Families First*. This would imply that the data collection process as instigated in this study, is to continue in this, or another (perhaps somewhat reduced) form. Initiatives for such quality assessments have already been taken.

The effects of the distinguished forms of intensive non-residential family treatment for specific target groups is a question which needs due attention paid in subsequent studies. Currently, several forms of intensive non-residential family treatment are distinguished, which all profess to prevent impending child placement (see Baartman, 1993). It would be desirable to find out which form of intensive non-residential care would be most appropriate for certain kinds of children from certain kinds of families. A clear answer to this obvious question, however, cannot be expected in the near future. Forty years of research in the field of care in which most research has been conducted, namely that of individual psychotherapy, has resulted in not much more than the conclusion that psychotherapy does help. However, we are still far from establishing which form of therapy is appropriate for which type of client dealing with what type of problem (Kazdin, 1994). Therefore, it is impossible to be on a more advanced level in the process of answering this more specific efficacy question in the relatively 'young' field of research of family treatment. What is required in the first place, is descriptive research which maps referral complaints, provided treatment and the results thereof. Conducting this type of research is currently beginning to develop (Ten Brink and Veerman, 1996). This may serve as a descriptive basis on which differential efficacy research may be expanded. In addition, it is made possible to link treatment provided with enrollment difficulties and results, which in turn ensures research into the process of intensive non-residential family treatment and provide insight into certain mechanisms of change (De Kemp, 1995).

Furthermore, it is strongly recommended to establish the pattern of child placement and follow-up help for the entire study group during the year after the follow-up year. With this may be checked whether the follow-up contacts indeed have the supposed protective effect (the number of child placement cases would have increased according to this line of thought). In that case, it would advocate more strongly a system of regular short 'social injections' after a period of intensive treatment. With this, care could stay both close at home and become more cost-effective.

Finally, results of this treatment do not only have direct influence on acting and thinking in care practice. It is of equal, if not of more, importance that the co-operation between program development and research has an influence on the nature of the program (see Veerman, 1997). Completing questionnaires (or having them completed), reporting to researchers, conducting follow-up interviews all provide the program with its current reputation. These activities give the program structure, make parents and those providing treatment sensitive to relevant aspects of the situation of children or the family, serve as a support to diagnostics and, in addition, contribute to more profile within and outside the field of study.

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L.T. (Tjeerd) ten Brink has been employed by the Pedological Institute in Duivendrecht/Amsterdam since September 1992, at the Evaluative-epidemiological department. He has conducted doctoral research into the development of children during a period of out-patient child care. Since 1994, he has been involved in the implementation of evaluation research '*Families First* the Netherlands'. For the greater part this concerns support of data processing and the development and maintenance of the Management Information System made for *Families First*. In addition to this, he is also involved in research into the various forms of Intensive Non-residential Family Care, instrument development and in a project aimed at providing more structure in the diagnostic process and formulating the diagnostic process (diagnostic information provision).

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In addition to renewal and improvement, the institute aims at strengthening the sector as a whole, a task entrusted primarily to the Centrum voor Beroeps- en Opleidingsvraagstukken (Centre for Professional and Vocational Training Affairs) and the Informatiecentrum Zorg en Welzijn (Information Centre of Care and Welfare). The International Centre offers its intermediary and supporting services for co-operation on international levels.

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